		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0029942

Facility Name: LAKE FRONT HEALTHCARE CTR

Address: 7618 NORTH SHERIDAN RD. (Number) CHICAGO (City) 60629 (Zip Code)

County: COOK

Telephone Number: (773) 743-7711 **Fax #** (773) 761-3387

IDPA ID Number: 36-3374548

Date of Initial License for Current Owners: 08/16/85

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2003 to 12/31/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) HERMAN MERMELSTEIN
(Title) VICE PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number LAKE FRONT HEALTHCARE CTR # 0029942 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,135	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	656	46	1,331	2,033	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	21,198	1,499	1,230	23,927	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,854	1,545	2,561	25,960	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.84%

D. How many bed-hold days during this year were paid by Public Aid? _____ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 8/16/85

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 8/16/85 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 12 and days of care provided 1,194

Medicare Intermediary AMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number LAKE FRONT HEALTHCARE CTR # 0029942 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	119,064	32,888	6,516	158,468		158,468		158,468			1
2	Food Purchase		159,823		159,823	(29,083)	130,740	(1,454)	129,286			2
3	Housekeeping	113,875	4,760		118,635		118,635		118,635			3
4	Laundry		8,325	2,217	10,542		10,542		10,542			4
5	Heat and Other Utilities			66,747	66,747		66,747		66,747			5
6	Maintenance	18,350	2,492	28,888	49,730		49,730	385	50,115			6
7	Other (specify):*			12,250	12,250		12,250		12,250			7
8	**TOTAL General Services**	251,289	208,288	116,618	576,195	(29,083)	547,112	(1,069)	546,043			8
	B. Health Care and Programs											
9	Medical Director			2,112	2,112		2,112		2,112			9
10	Nursing and Medical Records	909,617	72,271	12,181	994,069		994,069		994,069			10
10a	Therapy			1,332	1,332		1,332		1,332			10a
11	Activities	59,176	5,243	2,683	67,102		67,102		67,102			11
12	Social Services											12
13	Nurse Aide Training											13
14	Program Transportation			185	185		185		185			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	968,793	77,514	18,493	1,064,800		1,064,800		1,064,800			16
	C. General Administration											
17	Administrative	162,218			162,218		162,218		162,218			17
18	Directors Fees											18
19	Professional Services			42,807	42,807		42,807		42,807			19
20	Dues, Fees, Subscriptions & Promotions			37,502	37,502		37,502	(25,993)	11,509			20
21	Clerical & General Office Expenses	65,213	5,160	21,418	91,791		91,791	(6,100)	85,691			21
22	Employee Benefits & Payroll Taxes			198,728	198,728	29,083	227,811		227,811			22
23	Inservice Training & Education											23
24	Travel and Seminar			298	298		298		298			24
25	Other Admin. Staff Transportation			2,312	2,312		2,312	(2,312)				25
26	Insurance-Prop.Liab.Malpractice			88,795	88,795		88,795		88,795			26
27	Other (specify):*											27
28	**TOTAL General Administration**	227,431	5,160	391,860	624,451	29,083	653,534	(34,405)	619,129			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,447,513	290,962	526,971	2,265,446		2,265,446	(35,474)	2,229,972			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: LAKE FRONT HEALTHCARE CTR #0029942 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	6,219	
	REPAIRS & MAINTENANCE		297	
			0	6,516
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		2,217	
			0	2,217
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		26,025	
	ELECTRICITY		29,615	
	WATER		11,107	
	CABLE TV - LOBBY		0	
			0	66,747
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		560	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		680	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		16,822	
	ELEVATOR MAINTENANCE & REPAIR		10,826	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		0	
	FIRE SERVICE		0	
			0	
			0	
			0	28,888
7	**OTHER**			
	SCAVENGER		9,143	
	SECURITY SERVICE		3,107	12,250
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	2,112	2,112

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	3,020	
	LABORATORY & XRAY EXPENSE		2,396	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	0	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	6,000	
	RN CONSULTANT	XVIII B 38-2	0	
	DENTAL		765	
			0	12,181
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	1,332	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	1,332
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,683	
			0	2,683
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	0
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number LAKE FRONT HEALTHCARE CTR **#0029942** **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		185	185
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	0	0
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	17,565	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	25,242	
			0	42,807
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	3,528	
	EMPLOYEE WANT ADS	XIX F	1,062	
	CONTRIBUTIONS	VI 20 XIX F	20,850	
	DUES & SUBSCRIPTIONS	XIX F	7,673	
	LICENSES & PERMITS	XIX F	2,400	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	1,010	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	400	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	205	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	374	37,502
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		1,610	
	EQUIPMENT REPAIR & MAINTENANCE		767	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	4,490	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		14,551	
	MESSENGER SERVICE		0	
			0	21,418

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	109,864	
	UNEMPLOYMENT COMPENSATION	XIX D	8,347	
	WORKERS COMPENSATION INSURANCI	XIX D	27,625	
	HOSPITALIZATION INSURANCE	XIX D	47,031	
	EMPLOYEE BENEFITS - OTHER	XIX D	2,585	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	3,276	198,728
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	298	
	TRAVEL	XIX G	0	
			0	
			0	298
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		2,312	2,312
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		88,795	88,795
27	**OTHER**			
	BAD DEBTS	VI 24	0	
			0	0

GRAND TOTAL COLUMN 3 OTHER 526,971

Facility Name & ID Number LAKE FRONT HEALTHCARE CTR #0029942 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			77,575	77,575		77,575	2,482	80,057			30
31	Amortization of Pre-Op. & Org.			9,088	9,088		9,088		9,088			31
32	Interest			199,894	199,894		199,894		199,894			32
33	Real Estate Taxes			119,074	119,074		119,074		119,074			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			532	532		532		532			35
36	Other (specify):*											36
37	**TOTAL Ownership**			406,163	406,163		406,163	2,482	408,645			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		43,611	36,100	79,711		79,711		79,711			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,203	54,203		54,203		54,203			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		43,611	90,303	133,914		133,914		133,914			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,447,513	334,573	1,023,437	2,805,523		2,805,523	(32,992)	2,772,531			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number LAKE FRONT HEALTHCARE CTR # 0029942 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	2,482	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,454)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(2,312)	25		16
17	Non-Care Related Fees	(400)	20		17
18	Fines and Penalties	(4,490)	21		18
19	Entertainment		20		19
20	Contributions	(21,055)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(3,528)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,010)	20		28
29	Other-Attach Schedule	(1,225)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (32,992)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (32,992)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

LAKE FRONT HEALTHCARE CTR

ID# 0029942

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 385	6	1
2	BANK CHARGE	(1,610)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,225)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number LAKE FRONT HEALTHCARE CTR # 0029942 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,454)	0	0	0	0	0	0	0	0	0	0	(1,454)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	385	0	0	0	0	0	0	0	0	0	0	385	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,069)	0	0	0	0	0	0	0	0	0	0	(1,069)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(25,993)	0	0	0	0	0	0	0	0	0	0	(25,993)	20
21	Clerical & General Office Expenses	(6,100)	0	0	0	0	0	0	0	0	0	0	(6,100)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(2,312)	0	0	0	0	0	0	0	0	0	0	(2,312)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(34,405)	0	0	0	0	0	0	0	0	0	0	(34,405)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(35,474)	0	0	0	0	0	0	0	0	0	0	(35,474)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number LAKE FRONT HEALTHCARE CTR # 0029942 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	2,482	0	0	0	0	0	0	0	0	0	0	2,482	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	2,482	0	0	0	0	0	0	0	0	0	0	2,482	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(32,992)	0	0	0	0	0	0	0	0	0	0	(32,992)	45

Facility Name & ID Number LAKE FRONT HEALTHCARE CTR # 0029942 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
MALKA MERMELSTEIN	50	COMMUNITY NURSING & REHAB, LLC	NAPERVILLE			
HERMAN MERMELSTEIN	50					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$	N/A		$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number LAKE FRONT HEALTHCARE CTR # 0029942 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MALKA MERMELSTEIN	ADMINISTRATOR	ADM	50.00		50	100.00	SALARY	$ 100,770	17-1	1
2											2
3	HERMAN MERMELSTEIN		PURCH. ACCT	50.00		30	100.00	SALARY	10,000	17-1	3
4											4
5	BLUMA JEREMIAS	ASST. ADM.	MEDICARE			24	100.00	SALARY	25,289	17-1	5
6	(DAUGHTER)		BILLING								6
7											7
8	MARK WELDLER	ADM. CONS.	ADM. CONS.		SEE ATTACHED	10	17.00	SALARY	26,159	17-1	8
9	(SON-IN-LAW)										9
10											10
11											11
12											12
13								TOTAL	$ 162,218		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number LAKE FRONT HEALTHCARE CTR # 0029942 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number LAKE FRONT HEALTHCARE CTR # 0029942 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	ORIX R/E CAP. MARKETS LLC		X	MORTGAGE LOAN	$23,560.00	8/96	$ 2,600,000	$ 2,128,874	8/13/16	9.1000	$ 197,321	1
2												2
3												3
4												4
5												5
	Working Capital											
6	AMERICAN NAT'L BANK		X	LINE OF CREDIT						PRIME +	2,573	6
7												7
8												8
9	TOTAL Facility Related				$23,560.00		$ 2,600,000	$ 2,128,874			$ 199,894	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,600,000	$ 2,128,874			$ 199,894	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number LAKE FRONT HEALTHCARE CTR # 0029942 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 116,462	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 117,768	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,306	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 117,768	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 119,074	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	115,214	8
	1999	114,439	9
	2000	113,510	10
	2001	116,462	11
	2002	117,768	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2002 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME LAKE FRONT HEALTHCARE CTR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0029942

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-29-108-011-0000	NURSING HOME	$ 58,884.03	$ 58,884.03
2.	11-29-108-012-0000	NURSING HOME	$ 58,884.03	$ 58,884.03
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 117,768.06	$ 117,768.06

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number LAKE FRONT HEALTHCARE CTR # 0029942 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,691 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1993	$ 392,000	1
2					2
3	TOTALS			$ 392,000	3

Facility Name & ID Number LAKE FRONT HEALTHCARE CTR # 0029942 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	99		1993		$ 2,230,000	$ 57,179	39	$ 57,179	$	$ 578,946	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	TILING			1989	6,000	190			(190)	6,000	9
10	IMPROVEMENTS			1992	12,768	405	10		(405)	12,768	10
11	REMODEL LOUNGE			1993	1,685	43	39	43		439	11
12	BUILDING IMPROVEMENTS			1994	14,175	363	39	363		3,434	12
13	INSTALL DRYWALL, SPRINKLER SYSTEM			1995	10,987	282	39	282		2,186	13
14	INSTALL COLE BASE			1995	6,455	166	39	166		1,390	14
15	INSTALL CONCRETE ON FRONT			1995	1,500	38	39	38		316	15
16	NEW SLIDING WINDOW			1995	750	19	39	19		158	16
17	SEWAGE PUMP			1995	1,325	33	39	33		265	17
18	INSTALL NEW LIGHTS & ELECTRICAL			1996	1,850	47	39	47		347	18
19	ROOF FLASHING			1996	600	16	39	16		118	19
20	CONCRETE WORK			1996	3,850	99	39	99		730	20
21	WATER COOLER & PLUMBING			1996	3,404	87	39	87		656	21
22	TWO CONDENSOR COILS			1997	13,330	342	39	342		2,237	22
23	ALARM SYSTEM & ACCESS DOORS			1998	63,882	1,637	39	1,637		8,648	23
24	DRYWALL & CONDUITS			1998	12,435	319	39	319		1,639	24
25	FIRE DAMPERS & EXHAUST SYSTEM			1998	21,993	564	39	564		2,890	25
26	DRY CHEMICAL SAFETY SYSTEM			1999	1,922	49	39	49		223	26
27	HYDRAULIC PUMPS FOR ELEVATOR			1999	6,542	168	39	168		763	27
28	PLUMBING			1999	6,500	167	39	167		758	28
29	PLUMBING - AUDIT ADJUSTMENT			1999	(1,500)						29
30	NATURAL GAS GENERATOR & ELECTRICAL HOOK UP			1999	11,721	301	39	301		1,367	30
31	FIRE PROOF DOOR			1999	344	9	39	9		41	31
32	NEW FLOORS			1999	16,484	423	39	423		1,921	32
33	CEMENT WORK (STEPS & RAMP)			1999	4,400	113	39	113		513	33
34	NEW ROOF			1999	28,700	734	39	734		3,335	34
35	ELEVATOR REHAB			2002	10,350	376	39	376		580	35
36	BATTERY BACKUP EXIT SIGNS			2002	2,217	81	39	81		124	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number LAKE FRONT HEALTHCARE CTR # 0029942 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	FIRE ALARM SYSTEM UPDATE	2002	$ 13,650	$ 496	39	$ 496	$	$ 765	37
38	DOORS	2002	3,600	131	39	131		202	38
39	SECURITY SYSTEM	2003	4,880	7	39	7		7	39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,516,799	$ 64,884		$ 64,289	$ (595)	$ 633,766	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LAKE FRONT HEALTHCARE CTR # 0029942 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 84,214	$ 4,426	$ 8,421	$ 3,995	10	$ 50,577	71
72	Current Year Purchases	5,900	3,540	295	(3,245)	10	295	72
73	Fully Depreciated Assets	219,248					219,248	73
74								74
75	TOTALS	$ 309,362	$ 7,966	$ 8,716	$ 750		$ 270,120	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	ADMINISTRATIVE	2001 TOYOTA AVALON	2001	$ 35,262	$ 4,725	$ 7,052	$ 2,327		$ 21,156	76
77	ADMINISTRATIVE	BUICK	1996	30,301					30,301	77
78										78
79										79
80	TOTALS			$ 65,563	$ 4,725	$ 7,052	$ 2,327		$ 51,457	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,283,724	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 77,575	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 80,057	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 2,482	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 955,343	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number LAKE FRONT HEALTHCARE CTR # 0029942 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 532 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number LAKE FRONT HEALTHCARE CTR # 0029942 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			35,449			35,449	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				43,611		43,611	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					651			651	13
14	TOTAL			$		$ 36,100	$ 43,611		$ 79,711	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number LAKE FRONT HEALTHCARE CTR # 0029942 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 201,159	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	284,851		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	37,218		6
7	Other Prepaid Expenses	2,054		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): REAL ESTATE ESCROW	110,060		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 635,342	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	392,000		13
14	Buildings, at Historical Cost	2,230,000		14
15	Leasehold Improvements, at Historical Cost	288,299		15
16	Equipment, at Historical Cost	374,925		16
17	Accumulated Depreciation (book methods)	(965,892)		17
18	Deferred Charges	87,578		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): COMPUTER SOFTWARE	17,812		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,424,722	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,060,064	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 172,407	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	40,972		30
31	Accrued Taxes Payable (excluding real estate taxes)	632		31
32	Accrued Real Estate Taxes(Sch.IX-B)	117,768		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 331,779	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,128,874		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,128,874	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,460,653	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 599,411	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,060,064	$	48

*(See instructions.)

Facility Name & ID Number LAKE FRONT HEALTHCARE CTR # 0029942 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 702,158	1
2	Restatements (describe):		2
3	ROUNDING ADJUSTMENT	(3)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 702,155	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(59,196)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(43,548)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (102,744)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 599,411	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number LAKE FRONT HEALTHCARE CTR # 0029942 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,741,565	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,741,565	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,266	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,266	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSIONS/COSTS NET	1,096	28
28a	AUTO USEAGE REPAYMENT	2,400	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,496	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,746,327	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	576,195	31
32	Health Care	1,064,800	32
33	General Administration	624,451	33
	B. Capital Expense		
34	Ownership	406,163	34
	C. Ancillary Expense		
35	Special Cost Centers	79,711	35
36	Provider Participation Fee	54,203	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,805,523	40
41	**Income before Income Taxes (line 30 minus line 40)****	(59,196)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (59,196)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number LAKE FRONT HEALTHCARE CTR # 0029942 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,766	2,834	$ 76,508	$ 27.00	1
2	Assistant Director of Nursing					2
3	Registered Nurses	14,135	16,615	305,886	18.41	3
4	Licensed Practical Nurses	7,935	9,322	151,475	16.25	4
5	Nurse Aides & Orderlies	41,382	46,104	375,748	8.15	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,973	5,474	59,176	10.81	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,499	14,809	119,064	8.04	15
16	Dishwashers					16
17	Maintenance Workers	2,030	2,139	18,350	8.58	17
18	Housekeepers	13,621	14,637	113,875	7.78	18
19	Laundry					19
20	Administrator	4,047	4,324	110,770	25.62	20
21	Assistant Administrator	4,173	4,173	51,448	12.33	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,290	4,841	65,213	13.47	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	112,851	125,272	$ 1,447,513 *	$ 11.55	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 6,219	1-3	35
36	Medical Director	O	2,112	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	0	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	2,683	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify) REHAB	S	1,332		46
47	PSYCHIATRIC		6,000		47
48	DENTAL		765		48
49	TOTAL (lines 35 - 48)		$ 19,111		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses	91	3,020	10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)	91	$ 3,020		53

Facility Name & ID Number LAKE FRONT HEALTHCARE CTR # 0029942 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MALKA MERMELSTEIN	ADMIN	50	$ 100,770
HERMAN MERMELSTEIN	ASST ADM	50	10,000
BLUMA JEREMIAS	ASST ADM		25,289
MARK WELDER	ASST ADM		26,159
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 162,218

B. Administrative - Other

Description	Amount
	$ 0
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ALPHA DATA	DATA PROCESSING	$ 2,726
PSD SOLUTIONS	DATA PROCESSING	3,728
HDSI	DATA PROCESSING	7,046
KRUPNICK, BOKOR, KAGDA	ACCOUNTING	12,550
AMERICAN EXPRESS	MEDICARE CONSULTANT	190
PERSONNEL PLANNERS	U.C.CONSULTANT	693
WINSTON & STRAWN	LEGAL	7,559
ACCU - MED SERVICE	DATA PROCESSING	4,065
ALTSCHULER,MELVIN & GLASS	ACCOUNTING	2,000
MIDWEST APPRAISAL		2,250
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 42,807

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 27,625
Unemployment Compensation Insurance		8,347
FICA Taxes		109,864
Employee Health Insurance		47,031
Employee Meals		#REF!
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		2,585
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		0
CHICAGO HEAD TAX		3,276
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ #REF!

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,062
Health Care Worker Background Check	374
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	4,538
TRUST/FRANCHISE/CONTRIB/ETC	21,455
LICENSES & PERMITS	2,400
DUES & SUBSCRIPTIONS	7,673
MGMT CO ALLOCATION	
TRUST/FRANCHISE/CONTRIB/ETC	(21,455)
Less: Public Relations Expense	(0)
Non-allowable advertising	(3,528)
Yellow page advertising	(1,010)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,509

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
EDUCATION & SEMINARS	298
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 298

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number LAKE FRONT HEALTHCARE CTR # 0029942 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	PAINTING/DECORATIN	2000	$ 2,320	3 YRS	$ 387	$ 774	$ 774	$ 385	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 2,320		$ 387	$ 774	$ 774	$ 385	$	$	$	$	$

Facility Name & ID Number LAKE FRONT HEALTHCARE CTR # 0029942 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $7640**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **YES** If YES, have these costs
been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **2,823** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X.** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
of Public Aid during this cost report period. $ **54,203**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed tc
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services fo
the patient census listed on page 2, Section B? **NO** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **#REF!** Has any meal income been offset against
related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo
residents? **NO** If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all othe
times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out
out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service
performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees